



ONCOLOGY SPECIALTY CARE PROGRAM

Phone: **844-223-7510**

Fax: **844-673-6161**

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Office Contact: _____ Phone: _____
 Email: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____ Adult Female Not of Reproductive Potential
 Other: _____ BSA: _____ m² Adult Male Not of Reproductive Potential

Prior Failed Therapies:

Reason for Discontinuation:

Date:

- | Prior Failed Therapies | Reason for Discontinuation | Date |
|------------------------|----------------------------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

6 REQUIRED INFORMATION: Front & back copies of pharmacy & medical cards along with charts & labs from last 90 days

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> AFINITOR®				
<input type="checkbox"/> FEMARA®				
<input type="checkbox"/> GLEEVEC®				
<input type="checkbox"/> HYCAMTIN®				
<input type="checkbox"/> KISQALI®				
<input type="checkbox"/> KISQALI® FEMARA® Co-Pack				
<input type="checkbox"/> RYDAPT®				
<input type="checkbox"/> SPRYCEL®				
<input type="checkbox"/> TARGRETIN®				
<input type="checkbox"/> TASIGNA®				
<input type="checkbox"/> TEMODAR®				
<input type="checkbox"/> XELODA®				
<input type="checkbox"/> ZOLINZA®				
<input type="checkbox"/> ZYTIGA®				
<input type="checkbox"/> OTHER _____				

Supportive Medications	Dosage & Direction	QTY	Refills
<input type="checkbox"/> Aranesp® <input type="checkbox"/> Emend® <input type="checkbox"/> Neupogen® <input type="checkbox"/> Sancuso® <input type="checkbox"/> Arixtra® <input type="checkbox"/> Granix® <input type="checkbox"/> Nplate® <input type="checkbox"/> Xgeva® <input type="checkbox"/> Caphosol® <input type="checkbox"/> Lovenox® <input type="checkbox"/> Procrit® <input type="checkbox"/> Zofran® <input type="checkbox"/> Creon® <input type="checkbox"/> Neulasta® <input type="checkbox"/> Promacta®			

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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